IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 96-1160

DOROTHY MATHIS, individually and as
Special Administrator for Jerome Mathis, deceased

Plaintiff-Appellant,

v.

J.W. FAIRMAN and GERONE JENKINS

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 93 C 3356 **James B. Moran,** *Judge.*

ARGUED OCTOBER 25, 1996--DECIDED JULY 24, 1997

Before POSNER, Chief Judge, and EASTERBROOK and ROVNER, Circuit Judges.

ROVNER, Circuit Judge. Jerome Mathis committed suicide while incarcerated at the Cook County Jail, awaiting trial on a murder charge. His mother, Dorothy Mathis, filed suit against Gerome Jenkins, one of the cadets (guards in training) at the jail, as well as J.W. Fairman, the Executive Director of the Cook County Department of Corrections. She contended that Jenkins' indifference to her son's condition, as well as the jail's failure to adequately staff the jail and to train its employees, proximately caused her son's death, in violation of the due process clause of the Fourteenth Amendment. The district court entered summary judgment in favor of the defendants, concluding that the record did not reveal a triable question of fact as to whether the defendants were deliberately indifferent to Mathis' condition. We affirm

the grant of summary judgment.

The pertinent facts are as follows. On June 9, 1991, Jenkins reported for work a bit after 8:00 a.m. for duty on Tier 1-D, Division 5 of the jail, a non-aggressive, protective custody tier where Mathis was housed. This was Jenkins' first day on the job: he had been hired less than a week earlier and had just completed a four or five-day orientation. He was responsible for supervising approximately twenty-five inmates. While making a visual check of the tier, Jenkins noticed Mathis mumbling to himself in the day room. When Jenkins approached Mathis, Mathis told him that an unnamed individual was going to kill him. Jenkins testified that he reported this to his supervisor, Lieutenant Henry Troka, although Troka did not recall the conversation. Troka's subsequent report did reflect that he spoke to Mathis himself that day, however. Troka did not believe that Mathis was in any serious risk of danger from anyone else, but decided to have Mathis transferred to a single cell just to be sure. He also concluded that Mathis ought to be given a psychological examination. Paramedic Scott Birmingham subsequently reached the same conclusion. He visited the tier at around 9:30 that morning and later spoke to Mathis for about ten minutes at the request of the prison staff. Mathis told Birmingham "that he was hearing voices of somebody wanting to kill him or he wanted to kill himself." Birmingham prepared a written request for a psychiatric consultation (over Mathis' objection) and sent Mathis in the company of a guard to Cermak Health Services, which provided health care to the inmate population. The record indicates that this occurred at some time between 10:00 and 11:00 a.m..[1] Mental Health

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1. Ms. Mathis suggests that the evaluation was actually done much earlier in the day. An entry in the jail's logbook indicates that Mathis was "sent out" at 6:20 a.m. and that he was making remarks to the effect that "someone was going to kill him." However, the logbook also indicates that at 10:17 a.m., Mathis

Specialist Constance Williams conducted an evaluation, and concluded that Mathis was stable and needed no psychological or psychiatric treatment. Mathis denied any suicidal impulses, revealed no history of psychological problems, and expressed the desire to be returned to his cell. He was, in fact returned to the tier, where he evidently remained concerned that someone was attempting to kill him. He telephoned his family expressing that worry, and in deference to Mathis' concern, the tier's logbook indicated that a close eye was to be kept upon him. According to Jenkins, Mathis was checked on every thirty minutes until the end of Jenkins' shift at 4:00 p.m. Jenkins indicated that at 3:55 p.m., he did a final visual check on Mathis, who repeated that someone was out to get him. Shortly before four o'clock, Jenkins was relieved by Melvertis Little. When Little conducted a visual inspection of the tier a short time later, she discovered Mathis hanging from a torn bed sheet that he had wrapped around an air vent in his cell. Officers cut him down within moments, and medical personnel arrived shortly thereafter. CPR was administered, but to no avail. At 4:52 p.m., Mathis was pronounced dead at a local hospital.

The district court concluded in a thorough analysis that the evidence did not support a due process claim against either Jenkins or Fairman. With respect to Jenkins, the court found that the facts at most suggested that Mathis had been

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"was taken to psyco [sic] ward." That is consistent with the report that Troka prepared after Mathis' death; it is also roughly consistent with Birmingham's notation that he had spoken to Mathis and sent him for the evaluation between 10:30 and 11:00 a.m Most compellingly, it jibes with the undisputed fact that Constance Williams, the specialist who evaluated Mathis, did not report for work until 10:02 a.m. that day.

acting strangely, which was not by itself sufficient notice that Mathis might harm himself. See Mem. and Order at 7, citing *State Bank of St. Charles v. Camic*, 712 F.2d 1140, 1146 (7th Cir.), *cert. denied*, 464 U.S. 995, 104 S. Ct. 491 (1983). The court noted that Mathis had no known history of mental illness or attempted suicide, and when sent for a psychological evaluation on the day of his death was determined not to present a risk to himself. Mem. and Order at 7-8. At the same time, Jenkins had exhibited no deliberate indifference to Mathis: he had reported Mathis' strange behavior to his superior earlier in the day, and had checked upon him regularly thereafter until moments before Mathis killed himself. Id. at 8-9. In that regard, the court rejected the plaintiff's suggestion that the logbooks and other documentation reflecting the defendants' efforts had been doctored to cover up their own failure to monitor Mathis. Id. at 10-13. In particular, the court did not think it significant that paramedic Birmingham, who was summoned immediately after Mathis was found dead, described the body as "cold" at 4:02 p.m. The plaintiff argued that if the body was already cold at that hour, Mathis must have already been dead for quite some time, which would in turn suggest that Jenkins had not, in fact, been checking on Mathis regularly that afternoon and had certainly not looked in on him at 3:55 p.m. But the reports of the Cook County Medical Examiner and a police detective who had investigated Mathis' death both indicated that Mathis' body was still warm much later, after Mathis had been taken to the hospital. The district court attributed the apparent conflict to the likelihood that medical personnel employ different means of determining when a body becomes cold, especially when that assessment is based merely on touch, which it apparently had been here. Consequently, the court did not believe that a material question of fact was presented as to just how long Mathis had been dead before his body was discovered. Finally, the court found insufficient evidence to support a finding that the jail had been inadequately staffed and that its guards had been inadequately

trained. The court had before it evidence that suicides at the jail had dropped dramatically since 1980, even as the jail population had nearly tripled. Staffing complied with the mandates of state law, and although guards occasionally worked alone, as Jenkins did, the record indicated that on the date of Mathis' death, several other officers were present on the tier and that officers from other tiers were able to respond to trouble within moments, as they did when Mathis was discovered hanging in his cell. Finally, although cadets like Jenkins may not have been trained in suicide prevention, the jail maintained a psychiatric unit for that purpose. Id. at 13-17.

The focus of Ms. Mathis' appeal is on the district court's conclusion that Mathis did not kill himself until sometime between 3:55 p.m., when Jenkins said he last checked on him, and around or shortly after 4:00 p.m., when the jail staff claimed they found him dead. Ms. Mathis makes two arguments in this regard. First, she contends that it was inappropriate for the district court on summary judgment to assume that Mathis' body was not already cold by the time his suicide was discovered, given the facial conflict between Birmingham's report and the reports of the medical examiner and the detective. She argues second that the district court should not have taken into consideration at all the latter two reports, given that they were first submitted with the defendants' reply memorandum below. *See Black v. TIC Investment Corp.*, 900 F.2d 112, 116 (7th Cir. 1990) (new evidence submitted on reply should not be considered on summary judgment unless non-movant is given opportunity to respond).[2]

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2. It is not clear whether the reports were "new" in the sense that the plaintiff and her counsel had not seen them before or "new" only in the sense that the defendants had not cited them in their initial summary judgment materials. We note that the record reflects neither an objection to the late citation of the reports in

Whether Mathis' body was indeed cold at four o'clock is a red herring, however. We shall assume, for the sake of argument, that it indeed was cold by that time as Ms. Mathis argues and assume further that her son had already been dead for quite awhile before jail personnel discovered what he had done. The latter assumption would put the veracity of Jenkins' averment that he checked on Mathis every half hour until 3:55 into question. That might, in turn, open the door to a finding that Jenkins did not follow his superior's order (as reflected in the logbook) to keep a close eye on Mathis that day; but the possibility of such a finding would not by itself suffice to win Ms. Mathis a trial.

This case founders on the requirement that there be proof of the defendants' knowledge that Mathis posed a danger to himself. A prison official violates the Eighth Amendment (which applies to persons who have been convicted) and the due process clause of the Fourteenth Amendment (which applies to pre-trial detainees like Mathis) when he is deliberately indifferent to a substantial risk of serious harm to an inmate, and a finding of deliberate indifference requires evidence that the official was aware of the risk and consciously disregarded it nonetheless. *Farmer v. Brennan,* 511 U.S. 825, 840-42, 114 S. Ct. 1970, 1980-81 (1994); *see also Salazar v.*

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the defendants' reply memorandum nor a request for leave to file a surreply or otherwise to respond to this evidence. *Contrast Provenz v. Miller,* 102 F.3d 1478, 1483 (9th Cir. 1996), petition for cert. filed, 65 U.S.L.W. 3756 (May 5, 1997) (No. 96-1770). Even at this juncture, Ms. Mathis has not indicated what she would have done if given the opportunity to respond to the reports and the arguments that the defendants made in reliance upon them. In any case, for the reasons that follow, we need not resolve this issue.

City of Chicago, 940 F.2d 233, 238-41 (7th Cir. 1991).[3] There is no dispute in this case that jail personnel knew Mathis was behaving strangely. They were concerned enough to have the paramedic speak with him, to have him evaluated psychologically, and, in deference to his fear that someone was trying to kill him, to have him placed in a single cell. But after evaluating Mathis, the mental health specialist concluded that Mathis did not pose a danger to himself and should be returned to the general population. At that point, as far as Jenkins and the other prison officials were concerned, any questions as to whether Mathis might kill himself had been resolved. We inquired at argument whether Constance Williams' conclusions were communicated to the jail staff, and we were told there was no evidence that they were. No matter. It was clear enough from Williams' decision to return Mathis to the general population of the prison rather than keeping him for observation in the psychiatric unit that she did not believe Mathis to be in danger. At that juncture then, Jenkins and the other guards had no notice of any suicidal tendencies or intent in Mathis. Although Mathis' odd behavior apparently continued that afternoon, there is no evidence that his behavior changed in a way that made the jail staff aware that he might harm himself. Contrast *Hall v. Ryan,* 957 F.2d 402, 405-06 (7th Cir. 1992); *Bragado v. City of Zion/Police Dep't,* 788 F. Supp. 366, 371-72 (N.D. Ill.

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3. The rights of a pre-trial detainee under the due process clause of the Fourteenth Amendment are "at least as great as the Eighth Amendment protections available to a convicted prisoner." *City of Revere v. Massachusetts Gen. Hosp.,* 463 U.S. 239, 244, 103 S. Ct. 2979, 2983 (1983). Whether they are greater is an unsettled question that the plaintiff does not pursue here. *See Estate of Cole v. Fromm,* 94 F.3d 254, 259 n.1 (7th Cir. 1996), *cert. denied,* 117 S. Ct. 945 (1997).

1992), 839 F. Supp. 551, 553-54 (N.D. Ill. 1993). The most that can be said, then, is that Jenkins and his colleagues were negligent in failing to keep a closer eye on Mathis than they did. That will not support the requisite finding of deliberate indifference, however. *See generally Farmer,* 511 U.S. at 835, 114 S. Ct. at 1977-78; *Langston v. Peters,* 100 F.3d 1235, 1237-38 (7th Cir. 1996); *Vance v. Peters,* 97 F.3d 987, 991-92 (7th Cir. 1996), *cert. denied,* 117 S. Ct. 1822 (1997); *see also, e.g., Camic,* 712 F.2d at 1146.

We therefore AFFIRM the grant of summary judgment in favor of the defendants.

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 96-1160

DOROTHY MATHIS, individually and as
Special Administrator for Jerome Mathis, deceased

Plaintiff-Appellant,

v.

J.W. FAIRMAN and GERONE JENKINS

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 93 C 3356 **James B. Moran,** *Judge.*

[July 24, 1997]

JUDGMENT — ORAL ARGUMENT

Honorable Richard A. Posner, Chief Judge
Honorable Frank H. Easterbrook, Circuit Judge
Honorable Ilana D. Rovner, Circuit Judge

The judgment of the District Court is AFFIRMED, with costs, in accordance with the decision of this court entered on this date.

IN THE UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DOROTHY MATHIS, individually and as
Special Administrator for Jerome Mathis, deceased

Plaintiff,

No. 93 C 3336

v.

J.W. FAIRMAN and GERONE JENKINS

Defendants.

MEMORANDUM AND ORDER

Jerome Mathis (Mathis or decedent) committed suicide while incarcerated at the Cook Countv Jail (CCJ). His mother filed suit pursuant to 42 U.S.C.A. §1983 against Gerone Jenkins (Jenkins), a cadet officer, and J. W. Fairman, the Executive Director of CCJ. Plaintiff alleges that Jenkins and CCJ's training and staffing policies were deliberately indifferent to Mathis' medical and psychological needs, and that these inadequacies proximately caused his death. Defendants are before this court pursuant to Federal Rule of Civil Procedure 56 on a motion for summary judgment. For the reasons set forth, defendant's motions are granted.[1]

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1. Defendants have also moved to to strike certain of plaintiff's responses to defendants' Rule 12(M) statement of facts. Since we find for defendants, we deny that motion.

BACKGROUND

When Mathis was first incarcerated[2] at the Cook County Jail 16 months prior to his death, he completed the standard intake or admissions procedures. A medical history was taken and a physical examination completed, both of which indicated that he was in good physical health. A mental health specialist employed by the Cermak Health Services conducted a primary psychiatric screening, which indicated no depression or suicidal ideations (Alaimo aff., def.mo.for sum.jdgmt, exh. D-1)). The decedent had no history of mental health problems, psychological disorders or depression as a child, and he never communicated any suicidal ideations to his family members. The CCJ admission form, which bears the decedent's signature, indicates that decedent had never attempted suicide.

On Sunday, June 9, 1991, Mathis was on a non-aggressive protective custody tier to which Jenkins had been assigned for the 8:00 a.m. to 4:00 p.m. shift. Jenkins reported to work just after 8:00 a.m. and made a visual check of the floor. Early that morning he witnessed the decedent talking to himself and approached him. Mathis told Jenkins that somebody was out to kill him but did not indicate who the perpetrator would be nor how it would be accomplished. Jenkins reported his observations and the conversation to Lieutenant Troka (Troka), who indicated that the decedent would be sent to Cermak Health Services (Cermak) for a psychiatric examination. Troka transferred Mathis to a single cell on the same floor and told Correctional Officer Oglesby to ensure that Jenkins kept a close watch over Mathis.

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2. Mathis was a pretrial detainee charged with murder.

Paramedic Birmingham also had a conversation with the decedent early that morning and concluded that a psychiatric evaluation was appropriate. He completed the necessary paperwork and sent Mathis to Cermak, where he was interviewed by Constance Williams, a mental health specialist. When asked, "Do you want to hurt yourself or do you want to hurt anybody else," Mathis denied any suicidal or homicidal ideations. Because he was not hallucinating and because he appeared stable and calm, Williams sent Mathis back to the general population with no special instructions. Jenkins returned from lunch around 12 p.m. and made his regular visual checks, with an additional check at 3:55 p.m.

At the 3:55 p.m. check, Jenkins did not observe any preparations for a suicide, and Oglesby witnessed Jenkins having a conversation with Mathis. At 4:00 p.m. the shift changed and Melvertis Little (Little), another cadet correctional officer, was to replace Jenkins on the tier. Between 4:00 and 4:05 p.m. (while Jenkins remained in the interlock), Little conducted her first visual check and saw that Mathis was hanging from a torn bedsheet which was wrapped around an air vent in his jail cell. She ran down from the upper deck, pointing towards Mathis' cell. Jenkins went to the cell, saw Mathis hanging there and called for assistance. Two veteran correctional officers (Cooper and Brown) responded to the call within one minute, cut Mathis down and administered cardiopulmonary resuscitation (CPR).

Plaintiff alleges that her son died because of the deliberate indifference of the correctional cadet, Jenkins, and because of CCJ's staffing and training policies, which plaintiff alleges were deliberately indifferent to the decedent's medical and psychological needs.

DISCUSSION

A. Standards on a Motion for Summary Judgment

A motion for summary judgment may be granted when there are no issues of material fact and the movant is entitled to a judgment as a matter of law. Fed.R.Civ.P. 56(c); *Renovitch v. Kaufman*, 905 F.2d 1040, 1044 (7th Cir. 1990). The movant must point to those portions of the record which demonstrate the absence of any genuine issue of material fact, *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986), and all reasonable inferences are drawn in favor of the non-movant, *see e.g. Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 157 (1970); *Bank Leumi Le-Israel*, B.M. Vat Lee, 928 F.2d 232, 236 (7th Cir. 1991). All of this means that summary judgment should be granted when it is clear that the plaintiff could not carry her burden of persuasion at trial on one or more elements.[3] *See generally Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249-50 (1986).

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3. There are two elements to a §1983 claim: (1) defendant acted under the color of state law, and (2) defendant's conduct deprived the victim of a right, privilege, or immunity secured by the Constitution or laws of the United States. 42 U.S.C.A. §1983; *Brown v. City of Lake Geneva*, 919 F.2d 1299, 1301 (7th Cir. 1990) (citing *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 150 (1970)).

   The due process clause of the Fourteenth Amendment guarantees pretrial detainees the same, if not greater, rights than the Eighth and Fourteenth Amendments guarantee convicted inmates. *See e.g., Martin v. Tyson*, 845 F.2d 1451, 1457 (7th Cir.) (citing *Bell v. Wolfish*, 441 U.S. 520, 536 n.16 (1979)), *cert. denied*, 488 U.S. 863 (1988); *Hall v. Ryan*, 957 F.2d 402, 404 (7th Cir. 1992) (citing *Revere v. Massachusetts General Hospital*, 463 U.S. 239 (1983).

B. Defendant Jenkins

Plaintiff first alleges that defendant Jenkins violated the decedent's constitutional right to be free from self-inflicted harm. To avoid summary judgment from being entered in favor of Jenkins, plaintiff must have submitted sufficient evidence for a reasonable juror to conclude by a preponderance of the evidence that defendant (1) was under a duty to protect the decedent from self-inflicted harm; (2) knew the decedent was suicidal; (3) and acted with deliberate indifference to decedent's psychological state of mind.

1. Oualified Tmmunity

Defendant argues that he is entitled to qualified immunity, the purpose of which is to protect governmental officials who perform discretionary functions from suit and liability. Jenkins would be entitled to such immunity if his conduct did not violate any "clearly established statutory or constitutional rights of which a reasonable person would have known." *Harlow v. Fitzgerald,* 457 U.S. 800, 818 (1982).[4]

There is no question that inmates are entitled (and were at the time of the decedent's suicide) to be protected from the type of self-inflicted harm at issue here:

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4. "[W]hile the very action in question need not have previously been held unlawful, the contours of the right must have been established so that the unlawfulness of the defendant's conduct would have been apparent in light of existing law. The purpose of this requirement is to ensure that a reasonable official would or should have been aware of the rights he or she may be violating." *Cleveland-Perdue v. Brutsche,* 881 F.2d 427, 430 (7th Cir. 1989) (citing *Anderson v. Creighton,* 483 U.S. 635 (1986)), *cert. denied,* 498 U.S. 949 (1990).

> Therefore, *Camic* and *Joseph* together clearly established in our Circuit before 1986 the rule that prison officials will be liable under Section 1983 for a pretrial detainee's suicide if they were deliberately indifferent to a substantial suicide risk.

Hall v. Ryan, 957 F.2d 402, 405 (7th Cir. 1992).

Defendant argues that even if it were clearly established that he was under an obligation to protect the decedent from suicide, it must also have been clearly established that his conduct amounted to deliberate indifference (def. mem. at 13). Defendant, however, misstates the law of qualified immunity. In *Hall*, the Seventh Circuit declined to grant summary judgment based on qualified immunity defense to prison officials because the guardian of the decedent's estate raised the jury question as to whether the defendants acted with wilful neglect.[5] *Hall*, 957 F.2d at 405. Similarly, we decline to grant summary judgment on grounds of qualified immunity because whether or not Jenkins' conduct was deliberately indifferent is a factual issue, with plaintiff insisting that Jenkins deliberately ignored a substantial suicide risk. *See Cleveland-Perdue, supra,* at 430.

2. Notice and Deliberate Indifference

Defendant also contends that he was not on notice as to decedent's suicidal tendencies and that he was not deliberately indifferent to decedent's suicidal ideations. And here he is on firmer ground.

What provides notice of a "substantial suicide risk"? A substantial risk is present when a pretrial detainee who is

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5. The court equated wilful neglect with deliberate indifference. *Hall*, 957 F.2d at 405.

suffering from drug withdrawal and sitting in the fetal position tells a correctional officer of her suicidal ideations and her feelings of unfitness as a mother, and that she will commit suicide should she be returned to her cell, *Hare v. City of Corinth. Ms.*, 36 F.3d 412, 413-14 (5th Cir. 1994) (denying summary judgment), *rehearing en banc* granted December 8, 1994, or where a detainee writes a suicide note, has wrist lacerations and yells nearly 12 times that she is going to commit suicide, *Bragado v. City of Zion/Police Dept.*, 839 F.Supp. 551, 553-54 (N.D. Ill. 1993). Merely acting in a violent or "freaky" manner is not sufficient notice of a potential for self-inflicted harm. *State Bank of St. Charles v. Camic*, 712 F.2d 1140, 1146 (7th Cir.), *cert. denied*, 464 U.S. 995 (1983).

In this case the decedent had no history of mental illness or attempted suicide, and in his 16 months of incarceration he displayed no suicidal tendencies. On the day of decedent's death, Jenkins witnessed him mumbling and talking to himself, had conversations with decedent regarding his fear of physical attack, and knew that decedent had been taken for a psychiatric evaluation and that he was to "keep close watch" over him.[6] At most, these facts point towards "acting in a 'freaky' manner" which, as a matter of law, is

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6. In addition, paramedic Birmingham indicated that "Jerome Mathis was brought to me by the correctional officers saying that he was hearing voices of somebody wanting to kill him or he wanted to kill himself" (Birmingham dep. at 17, 60-61, 67). However, Birmingham also stated that he did not have first-hand knowledge that decedent told the correctional officers that he wanted to kill himself, nor did Birmingham know if the correctional officer overheard his conversation with the decedent (id. at 68). Jenkins, in his deposition, testified that other correctional officers brought the decedent to Birmingham.

insufficient notice. That Mathis had been sent to Cermak for a psychiatric evaluation does not change this court's opinion. The psychiatric specialist recommended that the decedent be returned to the general population. There is no indication that she concluded that decedent was suicidal. Jenkins had no reason or to second-guess the medical conclusions of a professional psychiatric examiner. Under these circumstances no reasonable juror could conclude that defendant Jenkins was on notice as to Mathis' substantial risk of suicide.

Even though Jenkins was on notice as to Mathis' perception that others sought to harm him, we do not find his conduct to have been deliberately indifferent to Mathis' needs. Deliberate indifference is equated with criminal recklessness. *Farmer v. Brennan,* ___ U.S. ___, 114 S.Ct. 1970, 1979 (1994). In other words, the officer's conduct must be more egregious than negligence, or even gross negligence, yet it need not rise to the level of purposeful. *Id.* at 1978.

No reasonable juror could conclude that defendant Jenkins was deliberately indifferent to the needs of the decedent. Because there was no notice of a substantial risk of suicide, Jenkins was not obligated to keep watch over decedent's every move.[7] What did Jenkins actually do? Jenkins reported to work at 8:00 a.m. (Jenkins dep. at 7); he conducted a visual count at about 8:10 a.m. (Jenkins dep. at 12); at some point in the early morning he witnessed the decedent talking

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7. This statement should not be taken to mean that if there were notice of a substantial suicide risk that the correctional officers would be under a duty to witness the inmate's every move. This situation is not presented here and we do not pass on the merits of the arguments, although we do believe that the officer's conduct should be proportionate to the risk (as evidenced by the notice) involved.

to himself and had a conversation with the decedent when the decedent indicated that he feared for his life (Jenkins dep. at 14, 16); Jenkins reported the observation and conversation to his superior, Lieutenant Troka, who indicated that the decedent would be taken for a psychiatric evaluation (Jenkins Dep. at 14-17); Paramedic Birmingham referred the decedent to the psychological staff at Cermak for a psychiatric examination (Birmingham dep. at 17-18; CCDOC Non-Emergency Request for Psychiatric Evaluation, def.mo. for sum.jdgmt, exh. K); mental health specialist, Constance W[illi]ms, evaluated the decedent and ordered him back to the general inmate population (Williams dep., exh. 1); Jenkins returned from lunch around 12:00 p.m. and made a visual check (Jenkins dep. at 17-18); Jenkins made visual checks every 30 minutes from noon until 4:00 p.m., when his shift was over, and made an additional check at 3:55 p.m. (Jenkins dep., exh. 2 at 22). We do not think that any reasonable juror could conclude that reporting bizarre behavior to one's superior officer and making visual wing checks every 30 minutes is tantamount to criminal recklessness. Even the plaintiff's expert witness, Joseph Rowan, testified that Jenkins did everything possible for the decedent and did not act with deliberate indifference (Rowan dep., at 102-03, 108, 138, 151-52).

In addition, the manner in which Jenkins dealt with the decedents hanging body was not deliberately indifferent because backup officers must be present when one officer enters an inmate's cell, Ill. Admin. Code, title 20, §701.140(b)(3)(E) ("Backup personnel shall be available when cell doors to living quarters are opened"), except, possibly, when a hanging prisoner's feet are not touching the ground and it is obvious that the suicide is not a ruse. The record does not disclose the decedent's position, but Jenkins describes it as "hanging in a slumped position." Instead of charging Mathis' cell and cutting the torn bedsheet (which would have been impossible because the Illinois Department

of Corrections General Order 9.7.1 prohibited Jenkins from carrying a knife or other such sharp instrument), he called for assistance and attended the arrival of experienced correctional officers. These officers immediately cut down the decedent and performed CPR. This simply does not meet the "criminally reckless" standard.

Plaintiff disagrees with her own expert's assessment of Jenkins' conduct. The expert relied on the record. Plaintiff contends the record is false, the result of a massive cover-up. She contends that Jenkins "prepared false logbook entries and other correctional officers prepared false reports to cover-up Jenkins' wrongdoing" (pl. mem. at 2, 13-14), but these attempts to manufacture a jury question are insupportable. First plaintiff argues that Jenkins' supervising officer, Oglesby, manufactured proof of the 3:55 p.m. visual check. Plaintiff claims that Oglesby wrote in her incident report "that she 'saw inmate Mathis and Cadet Jenkins talking' at 3:55 p.m.," but said in her deposition that "she 'never saw Mathis,' but that she had seen Jenkins standing 'at the window [to Mathis' cell] longer than he usually [required to check on a cell]'." Plaintiff misquotes Oglesby's response to the question posed at her deposition:

> Q: Did you ever see Mathis and Jenkins talking?
> A: I never saw Mathis. I saw Jenkins at the window. *He was talking to Mathis I asked him.* He stood at the window longer than he usually check. When he go out and check, he just look and make sure, but he stood at Jenkins's door a little longer. When he came down, 1 asked him what he was talking to Mathis about.

(Oglesby dep. at 15) (emphasis added). That deposition testimony is entirely consistent with Oglesby's incident report. Thus, there is no evidence from which a reasonable juror could conclude that Oglesby manufactured evidence to

coverup Jenkins's alleged deliberate indifference.

Plaintiff also tries to manufacture a jury question by writing:

> Jenkins wrote in his report that he had spoken with Mathis at 3:55 p.m. and that Little reported the hanging at 4:04 p.m. (Plaintiff's Exhibit 8.) The conversation with Mathis at 3:55 p.m. is inconsistent with Mathis' body being cold at 4:02 p.m.; Little could not have reported the hanging at 4:04 p.m. if, as paramedic Birmingham reported, the paramedics were notified at 4:00 p.m.

(plf. mem. at 14). There are two problems with this attempt to manufacture a jury question. First, the time discrepancy between the hanging being reported at 4:04 p.m. and the paramedics being notified at 4:00 p.m. does not rise to a constitutional violation. Paramedic Birmingham admitted that the times in his report were as per his watch, not an official timepiece (Birmingham dep. at 73- 74); thus any such discrepancy is immaterial. Second, Birmingham may have noted that decedents body was cold at 4:02 p.m., but the Cook County Medical Examiners report clearly indicates that it was still warm at 6:45 p.m. and was absent of rigor mortis (def. Rule 12(M) reply, exh. 1 at 1), and Detective Mike Miller noted that the body was warm to the touch at St. Anthony Hospital Emergency Room (def. Rule 12(M) reply, exh. 2 at 3). Even Birmingham admitted that different medical care-givers have different means of measuring when a body "goes down." We think it likely that they also have different means of measuring when a body "goes cold," especially when, as far as we can tell, the conclusion is based upon touch.

Third, plaintiff alleges that Lieutenant Troka's report that the decedent was sent for a psychiatric evaluation at 10:17 a.m. was fabricated. While it is true that the logbook indicates that decedent was sent out somewhere at 6:20 a.m., this

does not preclude his having been sent out a second time. Moreover, there is overwhelming evidence that decedent was sent out at 10:17 a.m. First, Lieutenant Troka's report states: "At 1017 hrs. "reporting lieutenant] sent inmate Jerome Mathis #9008739 to Cermak Hospital for a psych evaluation. He was returned to Division V General Population, per the evaluation" (Troka dep., exh. 2). Second, the logbook has a notation that the decedent was sent for a psychiatric evaluation at 10:17 a.m. (Troka dep.; Jenkins dep., exh. 2). Third, Birmingham, who was on the 8:30 a.m. to 4:30 p.m. shift, referred decedent to the psychological staff of the Cermak Health Center between approximately 10:30 a.m. to 11:00 a.m. (Birmingham dep. at 7, 17-18; CCDoC Non-Emergency Request for Psychiatric Evaluation, def. mot for sum. jdgmt, exh. K). Fourth, decedent was interviewed by Constance Williams (Williams dep. exh. 1) who was on the 10:00 a.m. to 6:00 p.m. shift on Sunday, June 9, 1991 (aft. of Lynette Elmore, def. Rule 12(M) reply, exh. 3). Finally, Chief Knight's report indicates that the decedent was sent to psychiatric services during the 8:00 a.m. to 4:00 p.m. shift (pl. Rule 12(N) stmt., exh. 2, citing Lieutenant Troka's report). Thus, all the evidence indicates that the decedent was sent for a psychiatric evaluation around 10:17 a.m., and unless a juror were to reject all of it, there would be no question of fact. Witness credibility, standing alone, cannot be reason for denying summary judgment because this approach would eviscerate Rule 56.

Finally, plaintiff tries to find a cover-up in the difference between the entries in Jenkins's logbook (pl. mem. at 10-11). Plaintiff argues that the entries for 3:00, 3:30 and 3:55 are fabricated because

> [t]he entries for 1:00 p.m., 1:30 p.m., 2:00 p.m., and 2:30 p.m. contain notation of the number of inmates on the tier; this information is not included for the entries for 3:30 p.m. and 3:55 p.m. Moreover, the entries for the checks before 3:00 p.m. refer to a "visual wing

check." The entries for 3:30 p.m. and 3:55 p.m. do not refer to a "visual wing check," but state only that "wing remains lock [sic] all appears secure."

These minor discrepancies are not sufficient for a reasonable juror to conclude to a degree of certainty greater than 50% that there was a cover-up.

Summary judgment is granted as to defendant Jenkins for failure to show either notice and deliberate indifference or that there was a coverup.

C. Defendant Fairman and Official CCJ Policy

Plaintiff has also named J.W. Fairman, in his official capacity as the Director of Cook County Department of Corrections, a defendant in this action for maintaining inadequate and unconstitutional training and staffing policies which were deliberately indifferent to the decedent's medical and psychological needs, and which were the proximate cause of the decedent's suicide.

The failure to train and inadequate staffing cases, which result in a jail suicide, require the plaintiff to show that the defendant was deliberately indifferent to the decedents needs and rights, and that such indifference was the proximate cause of the victim's injuries. *See City of Canton v. Harris,* 489 U.S. 378, 388 (1988) (failure to train); *Benson v. Cady,* 761 F.2d 335, 341 (7th Cir. 1985) (quoting *Wellman v. Faulkner,* 715 F.2d 269, 272 (7th Cir. 1983) (inadequate staffing); *Anderson v. City of Atlanta,* 778 F.2d 678 (llth Cir. 1985) (inadequate staffing).

Plaintiff's expert here focuses on response time. He contends that the then jail policy (which has since been changed) of permitting cadets with limited training to work alone on a tier, although under the visual supervision of an experienced supervisor, evidenced deliberate indifference because cadets are not trained to immediately enter a cell and cut down a hanging prisoner. Thus the decedent may still have been alive

when Jenkins first saw him hanging and perhaps could have been saved if the cadet had immediately responded. Plaintiff points to this suicide and one the previous day as evidence of what can happen when inadequately trained personnel are pressed into service as correctional officers.[8] We begin by noting that even the report of the plaintiff's expert witness belies plaintiff's position that Fairman was criminally reckless:

> [S]ince 1980, CCJ [Cook County Jail] has averaged only two completed suicides per year, or a 77 percent reduction--this, when the average daily population skyrocketed from 3,700 to 9,600, or a 260 percent increase.

Joseph R. Rowan, *Suicide Prevention: Debunkina the "Experts"*, 5 American Jails 21, 24 (Nov/Dec 1994) (emphasis in the original) (def. mot for sum. jdgmt., exh. Q). A decrease in the number of jail suicides that occurs during a simultaneous increase in the number of jail inmates and detainees flies in the face of a claim of institutional deliberate indifference.[9]

Second, Title 20 of the Illinois Administrative Code, sections 701.20(b)(1)(B-C), set the staffing requirements for a

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8. The earlier death seems to have resulted from the cadet's gross negligence and not any training policies (Velarde mem., pi. Rule 12(N) stat., exh. 3).

9. And, the August 21, 1991, handwritten memorandum, which was written two months after the decedent's suicide, stated: "Continue to stress the need to look for signs of potential suicides during your training sessions at the Cook County Training Academy. This appears to be all we can do at this time" (id.). Thus, if anything, these two memos indicate that officials were aware of and worried about jail suicides.

jail:

> (B) No person shall be confined without an officer on continuous duty in the jail, awake and alert at all times.
>
> (C) If the facility has more than one floor of detention, one jail officer shall be required for each additional floor when 15 or more detainees are confined.

Ill. Admin. Code §§701.20(b)(1)(B, C). Even if §1983 liability could be based on a violation of state law, there is no evidence indicating that this statutory requirement was not met.

That does not, of course, absolve the governmental body if the use of untrained personnel demonstrated deliberate indifference. But cadets were not wholly untrained and they were supervised. Cadet correctional officers receive 40 hours of orientation training prior to an assignment, including some suicide prevention, and eight hours of CPR training and certification (Wiliams aff., def.mo. for sum.jdgmt., exhs. N. N-2, N-2). Cadets apparently, however, were not then trained in how to respond to a suicide. They were, though, assigned to tiers with supervising officers who completed 400 additional hours of training at the academy and 40 hours of continuing education each year. In addition, CCJ maintains psychiatric units[10] for suicidal inmates, staffed by correctional officers who have received substantial training in suicide prevention (Alaimo aff., def.mo. for sum.jdgmt., exh. D).

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10. The Cermak Health Service's medical and psychiatric staff administers the care to inmates placed in either the CCJ Division VIII Acute Care Unit or the CCJ Division VIII Residential Treatment Unit.

Finally, even if cadets sometimes worked alone because there was not always "enough manpower to assign a cadet and a correctional officer to work in each wing" (Troka dep. at 46),[11] Jenkins was not working alone. Lieutenant Troka was Jenkins' supervisor that day. Officer Oglesby was present on the tier when Jenkins conducted his final visual check at 3:55 p.m. When Jenkins saw Mathis hanging and called for assistance, two veteran officers outside the tier responded to the call within a minute or so.

We are left, then, with a situation in which the decedent had been determined by Cermak not to be a suicide risk; and the apparent risk was that a prisoner not identified as suicidal would seek to take his own life, would be observed in the few minutes before the attempt was successful, and the response time would be briefly delayed. We remain unclear whether or not the decedent's position permitted Jenkins to enter the cell without backup and where he was supposed to get an instrument to cut down the decedent. The use of cadets in the fashion they were then employed may well have been imprudent, given the various emergencies that can arise in a jail setting, but we cannot conclude that a reasonable jury could determine that the decedent's death was due to institutional deliberate indifference.

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11. Fairman is an employee of the Sheriff of Cook County. If the lack of staff was due to budget constraints imposed by the County Board over the objection of the Sheriff, it may well be that any inadequate staffing claim should be directed at the County Board. See 55 ILCS 5/3-15015; *Houston v. Sheahan*, 62 F.3d 902, 903 (7th Cir. 1995) (per curiam); *Leffler v. Meer*, 60 F.3d 36, 374 (7th Cir. 1995); *Wilson v. Cook County Bd. of Commissioners*, 878 F.Supp. 1163, 1170 (N.D.Ill. 1995).

CONCLUSION

For the foregoing reasons, summary judgment is granted as to both defendant Gerone Jenkins and defendant J.W. Fairman.

December 28, 1995.

JAMES B. MORAN,
Senior Judge, U.S. District Court